## Major Medical Health Insurance Comparison

Instructions: Complete this form for each health insurance policy you are considering and compare the results.

| | |
|---|---|
| Health Insurance Carrier Name: | |
| Plan Name: | |
| Insurance Carrier Rating (AM Best & Co): | |
| Name of Preferred Provider Organization/Network: | |

| **Deductible, Coinsurance and Out-of-Pocket** | **In-Network:** | **Out-of-Network:** |
|---|---|---|
| Calendar Year **Deductible** per INDIVIDUAL | **$** | **$** |
| **Coinsurance** (the % the plan pays after the deductible) | **%** | **%** |
| Calendar Year **Maximum Out-of-Pocket** per INDIVIDUAL (your financial responsibility after the deductile is satisfied until the plan pays the remainder of covered expenses for the calendar year.) | **$** | **$** |
| Calendar Year **TOTAL FINANCIAL EXPOSURE** per **INDIVIDUAL** (the sum of Deductible + Maximum Out-of-Pocket) | **$** | **$** |
| **Total Number of Deductibles** per FAMILY that must be satisfied | #_____ | #_____ |
| Total Number of **Maximum Out-of-Pocket** per FAMILY | #_____ | #_____ |
| Calendar Year **TOTAL FINANCIAL EXPOSURE** per **FAMILY** (the sum of Deductibles per Family + Maximum Out-of-Pocket per Family) | **$** | **$** |

| **Policy Limits** | |
|---|---|
| Calendar Year Maximum Benefit per Individual: | **$** |
| Lifetime Maximum Benefit per Individual: | **$** |
| **Other** | |
| Rate Guarantee: | _____ **# of Year(s) or** _____ **# Months** |
| One-Time Enrollment Fee:<br>-Refundable | **$**<br>☐ **Yes** ☐ **No** |

| | |
|---|---|
| **ANNUAL PREMIUM:** | **$** |

Health Insurance Analysis

| Carrier Name: | Plan Name: | | |
|---|---|---|---|
| **Outpatient Coverage:** | | | |
| Physicial Office Visit Charge | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| Lab Sercices & Tests | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| X-Rays | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| Advanced Diagnostic Imaging (CAT Scans, MRI, etc.) | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| Non-Surgical Back Treatment (Chiropractic Services) | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| Mental, Nervous and Chemical Dependency | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| Outpatient Surgery | □ Deductible & Coinsurance | or | □ Copay |
| Ambulance (Ground, Air and Water) | □ Deductible & Coinsurance | or | □ Copay |
| -Cap on the dollar amount? | □ Yes □ No | | |
| **Preventive / Wellness Care:** | | | |
| Routine Mammography & Pap Smears | □ Deductible & Coinsurance | or | □ Copay |
| Routine Physicals | □ Deductible & Coinsurance | or | □ Copay |
| -Waiting Period | □ Yes □ No | | |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| Child Immunizations and Health Screenings | □ Deductible & Coinsurance | or | □ Copay |
| Colorectal Cancer Screening / PSA Testing | □ Deductible & Coinsurance | or | □ Copay |
| **Inpatient Coverage:** | | | |
| Hospitalization | □ Deductible & Coinsurance | or | □ Copay |
| -Additional Copayment? | □ Yes □ No | | |
| Surgery | □ Deductible & Coinsurance | or | □ Copay |
| -Additional Copayment? | □ Yes □ No | | |
| Mental and Nervous Care: | □ Deductible & Coinsurance | or | □ Copay |
| -Limit on the number of services? | □ Yes □ No | | |
| -Cap on the dollar amount? | □ Yes □ No | | |
| **Prescription Drugs:** | | | |
| Generic Rx | □ Deductible & Coinsurance | or | □ Not Covered |
| -Dollar limit per Rx or calendar year | □ Yes □ No | | |
| Brand Name Rx - Preferred or Formulary | □ Deductible & Coinsurance | or | □ Not Covered |
| -Dollar limit per Rx or calendar year | □ Yes □ No | | |
| Brand Name Rx - Non-Preferred or Non-Formulary | □ Deductible & Coinsurance | or | □ Not Covered |
| -Dollar limit per Rx or calendar year | □ Yes □ No | | |
| Specialty Medications | □ Deductible & Coinsurance | or | □ Not Covered |
| -Dollar limit per Rx or calendar year | □ Yes □ No | | |
| **Other:** | | | |
| Pre-Existing Condition Limitation: | | | |
| Exclusions & Limitations/Other Provisions: | | | |